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A study of caregivers of elderly veterans

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A STUDY OF CAREGIVERS OF ELDERLY VETERANS

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ABSTRACT

A STUDY OF CAREGIVERS OF ELDERLY VETERANS

by Rose H. Martinez

The purpose of this descriptive, exploratory study was to examine the caregiver-veteran dyad's performance of specific standing transfer techniques. The conceptual framework was Orem's Self-care Model (1980). Six female caregivers, and six chronically ill, elderly male veterans comprised six dyads who consented to participate in the study.

Of the 20-item structured questionnaire, six items were specifically related to the three modalities of standing transfer techniques taught to caregivers by licensed nurses. Also, the caregivers were each asked to demonstrate how they assisted the veteran to transfer using a step-by-step approach. All data were analyzed and reported in frequencies and percentages.

Results indicated that caregivers want training in standing transfer techniques. However, they do not think that one session implies learning, nor that training took place. Self-care abilities of the elderly veteran assisted the caregiver in standing transfers, and in continuing home based care.

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Chapter 1

INTRODUCTION

Studies of caregivers of non-institutionalized veterans indicate that most caregivers are aging spouses, middle-aged daughters, daughters-in-law, older female friends, and female neighbors (Brody, 1981; Fengler & Goodrich, 1979). The fact that caregivers are most often female reflects the traditional perception of females in our society, who are often viewed as nurturant and expected to care for sick family members (Brody, 1981; Shanas, 1979). Given this cultural heritage, it seems almost natural that wives become caregivers of spouses, or daughters become caregivers of fathers-in-law; likewise, female friends or neighbors assume the role of caregiver to male friends and/or neighbors (Cantor, 1983).

Under the conditions where the caregiver is a spouse, minor or no alterations in living arrangements may occur. In other situations, the caregiver may move into the veteran's home (Soldo & Myllyluoma, 1983). Or, if the veteran lives nearby, the caregiver may manage two households, the veteran's and her own (Arling & McAuley, 1983; Johnson & Catalano, 1983).

Duties involved in caregiving are numerous: Meal preparation, feeding, bathing, toileting, and dressing (Archbold, 1980; Clark & Rakowski, 1983; Maletta & Hepburn,

1986). One critical task that the caregiver needs to master is assisting the chronically ill veteran as he transfers from chair to bed, or from chair to standing position. This study focused on female caregivers who gave direct personal care to elderly, chronically ill veterans and who had training in transfer techniques.

Problem

The caregiver requires training in prescribed exercises that will help develop and maintain functional abilities of the affected veteran (Blechman, 1984; Maletta & Hepburn, 1986; Stroker, 1983) so he may continue in home-based care. Training in appropriate transfer techniques is required if caregivers are to safely move or guide movement of the chronically ill, elderly veteran from one place to another (Ellwood, 1982). Correct coordination of body posture, movement and balance helps prevent back injury to the caregiver (Okamoto, 1984, p. 18), and promotes the well-being of the veteran by preventing a fall.

Research Question

This study asked the question: Is the caregiver-veteran dyad performing standing transfer techniques according to training?

Purpose and Need

The purpose of this study was to examine the caregiver-veteran dyad as they demonstrated skills in standing

transfer techniques. Each caregiver received training in specific skills by licensed nurses.

If the caregivers do not have a clear understanding of their duties, and if they have not learned proper techniques for providing care, there may be serious consequences. The risk of sustaining a traumatic injury or falling while helping the elderly veteran with transferring activities increases as caregivers' physical capacities wear out. The outcome may be hospitalization of caregivers or of recipients of care. Therefore, adequate knowledge and skills of caregivers are important, especially because they provide the bulk of care to our elderly veteran population (Chenoweth & Spencer, 1986; Farkas, 1980).

Definition of Terms

For the purpose of this study, the following definitions apply:

1. Caregiver: A euphemism for the wife, daughter, daughter-in-law, or female friend or neighbor as a major source of support for the elderly (Brody, 1981).

2. Veteran: A former member of the armed forces.

3. Caregiver/dyad: A couple consisting of a husband-wife, or other form of relationship between two people.

4. Nurse: A person registered and legally licensed as a registered nurse or vocational nurse by state authority.

5. Transfer: "is a pattern of movement by which a patient moves from one surface to another" (Ellwood, 1982, p. 473).

6. Standing Transfer Technique: A set of specific movements for moving from wheelchair to bed, and back to wheelchair, from wheelchair to chair, and back to wheelchair, and from wheelchair to toilet, and back to wheelchair without the use of a slide board.

7. Self-care: Any activity that individuals initiate and perform on their own behalf to maintain life, health, and well-being (Orem, 1980).

Setting and Sample Population

Permission to conduct the study was granted by both the Institutional Review Board, Human Subjects of San Jose State University, and Human Subjects Committee of the Department of Veterans Affairs Medical Center (see Appendix D and Appendix E).

Veterans participating in this study were selected from those who were hospitalized and received physical therapy during a particular hospital admission. These elderly veterans were inpatients in a Geriatric Evaluation Unit (GEU) in a Department of Veterans Affairs Medical Center (VAMC) in northern California between November 1988 and April 1989. To qualify as candidates for this study the veterans had to be attending the Ambulatory Care Service as

follow-up clients on health maintenance at a particular VAMC in northern California.

A convenience sample of 12 caregiver-veteran dyads consisting of 12 female caregivers aged 45 years and over who were spouses, daughters, and daughters-in-law, or friends, and veterans aged 65 and older were selected from those who volunteered to participate in the study. These elderly veterans did not have a primary diagnosis of Chemical or Substance Dependence, or of Carcinoma. Typically they had a diagnosis of Diabetes Mellitus, Cardiovascular Accident (CVA), Hypertension, Chronic Obstructive Pulmonary Disease (COPD), or Peripheral Vascular Disease. Additionally, they were alert and able to transfer with assistance without a slide board.

Research Design and Methodology

This exploratory study used a descriptive approach. No specific hypothesis was tested.

Survey Instrument

The investigator developed a 20-item structured questionnaire that sought information about skills involved in standing transfer techniques. The structured questionnaire was based on Ellwood's transfer method (1982, p. 473), and skills training described by nurses who provided training to caregivers at this specific Veterans Medical Center.

This questionnaire on transfer techniques asked the caregivers to rate replies on a four-point scale (see Appendix B). The instrument was used to help determine the performance of standing transfer techniques. In order to assess retention of transfer skills by caregivers of discharged elderly veterans, checklists to evaluate knowledge of standing transfer techniques were used. These checklists were prepared by the investigator. The dyads participating in this research were asked to demonstrate how the veterans transferred from bed to wheelchair, and back; from wheelchair to regular chair, and back; and from wheelchair to toilet, and back (see Appendix C). Data were also collected on the following: The age of the caregiver, the caregiver's perception of her health status, and the relationship of the caregiver to the veteran (see Appendix A).

Procedure to Obtain the Population

The investigator worked as clinician in the Ambulatory Care Service clinic at a VAMC in northern California. She approached the caregivers and elderly veterans at the clinic and asked if they were interested in participating in a study. Those caregiver-veteran dyads that expressed interest were asked to give their mailing address to the investigator who mailed them an invitational letter and informed consent form (see Appendix F and Appendix G).

At the veteran's next clinic appointment, these respondents were interviewed and demonstrated standing transfer techniques.

Scope and Limitation

The sample was limited to caregiver-veteran dyads who volunteered to participate in the study. Randomization was not introduced in this study; thus generalization of findings is not appropriate. In addition, participating dyads were limited to those who fit the sample criteria for location of training in standing transfer techniques, age, and relationship to the veteran.

Data Analysis

This study used descriptive statistics to analyze the data. Findings from the questionnaire, caregiver profile, and checklists are reported in frequencies and percentages.

Chapter 2

CONCEPTUAL FRAMEWORK AND RELATED LITERATURE REVIEW

Conceptual Framework

The conceptual framework used for this study was Orem's self-care model (1980). This model consists of four major components: Person, environment, health, and nursing.

Person

Orem defines the person as the recipient of either total or partial care from the nurse (p. 6). Moreover, the person is described as a living organism with physiological and developmental needs which must be in balance to maintain life. The person is expected to function in the social community through the use of signs, and oral or written communication (Orem, p. 120).

Environment

Orem lists four elements of the environmental component of her self-care model. These include an environmental factor, an environmental element, environmental conditions, and developmental conditions.

Although Orem does not specify the nature of the environmental factor (p. 36) or the environmental element (p. 66), she does state that both are external to the person. Environmental conditions are also external, but they are related to physical and psychosocial situations (p. 66). Developmental conditions motivate the person to

set goals and to change behavior to obtain these goals (p. 61).

Health

For Orem, health is defined as a state of structural and functional soundness, that is, the absence of disease. Orem integrates the physical, mental, interpersonal, and social aspects of the person in her discussion of what is necessary to the person's health (Orem, p. 121).

Nursing

Orem distinguishes four major functions of nursing. Nursing as a helping discipline (p. 55), nursing ability (p. 87), the practice of nursing, and nursing care (p. 22). Nursing is a helping discipline concerned with individualized care (p. 55). The nurse is interested in the health perception of the patient because the mode of helping by the nurse will change according to the patient's perception of his health condition (p. 131). In her discussion of nursing ability, Orem includes three modes of provision: total care, partial care, and supportive-educative nursing (p. 96). Regarding the practice of nursing, Orem delineates educational preparation, and the role of the nurse (p. 24). Finally, in her discussion of nursing care, Orem focuses on preventive care, prevention of complications, and assisting the client to compensate for disabilities (p. 132).

Self-care Requisites

The practice of self-care is essential for human beings to maintain life, to prevent pathology, and to restore themselves in case of illness or injury (Orem, 1980, p. 41). Orem describes three types of self-care requisites: Universal, developmental, and health-deviation. Universal self-care requisites refer to all human beings' need for air, food, water, elimination, activity and rest, solitude, social interactions, safety, and a state of normalcy (p. 42). Developmental self-care requisites are a result of genetic make-up, or physical and psychosocial changes (p. 47). Health-deviation requisites, for Orem, are a person's pathological defects or disabilities (p. 50). According to Orem, when an individual is meeting universal, developmental, and health-deviation self-care requirements, the situation is one of therapeutic self-care demand (p. 52). Any interruption of this capacity is a self-care deficit (p. 27).

Applications of Orem's Model

One segment of the population that seems particularly suited to applications of Orem's model is the chronically ill veteran aged 65 years or older. If the chronically ill, elderly veteran maintains self-care regarding universal needs of air, food, water, elimination, activity, rest, solitude, social interaction, safety, and a state of

normalcy, he may consider himself "doing well" despite his illness (Orem, p. 37). As long as he can accomplish self-care within his environment, he does not request nursing care.

Episodes of exacerbation of chronic disease are responsible for health-deviation limits in mobility and self-care. When this occurs, the veteran may require nursing care in a hospital setting. During the initial illness crisis, the elderly veteran is too distraught to plan his care. He is dependent on the nurse and other health providers for his total care. At this time, the nurse's role is to act for and do for the veteran (p. 61).

Self-care Agency

As the elderly veteran's skills and abilities are regained, whether to minimal or maximal level, he is able to become involved in self-care activities such as feeding and transferring from place to place through standing, pivoting, and turning (Orem, p. 83). At first he needs much encouragement, practice, and strength. As he recovers, the veteran learns self-care activities, such as standing transfers, which are made easier by the guidance and support given by the nurse in an environment conducive to physical and psychosocial restoration (pp. 66-67). At this time, the nurse increasingly concerns herself with applications of the supportive-educative role Orem describes in her model.

When the elderly veteran can take part in food selection and self-feeding and can attend to his comfort and elimination requirements without too much assistance, he starts to think of going home. He may comment that he "doesn't need to be hospitalized anymore" (p. 52).

Therapeutic Self-care Demand

When the elderly veteran begins to ask questions regarding medication and treatments, and is able to respond to physical and psychosocial needs, the nurse continues to act in the supportive-educative role described by Orem and formulates a plan of care for the elderly veteran.

Factors of Planning and Discharge

Factors the nurse must consider in formulating the elderly veteran's plan of care include the therapeutic nature of self-care agency, the self-care deficits of the veteran, and the role of the probable self-care deficits of the primary caregiver who will have responsibility for the health and maintenance of the elderly veteran when he leaves the hospital. Usually, this primary caregiver is a female of middle age, most often the spouse, daughter, or daughter-in-law of the elderly veteran (Brody, 1981, p. 474).

The nurse has the knowledge and capability to make judgments and decisions in selecting self-care actions in appropriate sequence (Orem, p. 6). These judgments and decisions are influenced by the nurse's assessment of the

female caregiver's physical functioning skills and her motivation, characteristics which the caregiver has identified to the nurse. The nurse applies her knowledge of the caregiver as she designs a suitable plan of action, including delineation of the caregiver's role in caregiving tasks that involve new skills for actions such as standing transfers that were not needed when the elderly veteran was able to engage in self-care.

In applying Orem's model, the nurse's supportive-educative role includes instructing the caregiver as well as the elderly veteran, for both need training in methods to manage health-deviation self-care. Standing transfers, the activity emphasized in this study, are part of rehabilitative measures that help compensate for disabilities (Orem, p. 50). The nurse assists the caregiver by facilitating an environment conducive to developing her confidence. Teaching and guiding the caregiver as well as the elderly veteran through self-care activities, including standing transfers, provides learning experiences in a safe developmental environment (p. 67).

The nurse provides opportunities for the caregiver to observe the nurse assisting the elderly veteran as he completes self-care activities such as standing transfers. The caregiver can ask questions and verbalize her concerns. The nurse also provides an opportunity for the caregiver to

practice assisting the elderly veteran in an environment where professional help is immediately available. The caregiver, the elderly veteran, and the nurse can share the joy of small accomplishments, which is conducive to encouraging self-care practice.

Through the nurse's encouragement and instruction, the female caregiver learns to stand by and assist the elderly veteran; thus the developmental self-care requisite for mobilizing the elderly is achieved. Supportive-educative guidance, in accordance with Orem's model, is the appropriate nursing action (p. 101).

Review of Related Literature

This section is organized by three subtopics; within every section there will be a description of pertinent studies and related anecdotal reports. Characteristics of female caregivers are considered first, followed by consequences of care, and caregiver interventions.

It is documented that families provide 80% of care to impaired elderly members (Shanas, 1979); in fact, studies show that females are the primary caregivers of chronically ill, elderly persons. As early as 1969, Golodetz, Evans, Heinritz, and Gibson studied 59 caregivers, and found that 49 were unskilled, female spouses, or daughters; of these caregivers, 31 suffered chronic ailments themselves. Moreover, the only preparation in caregiving skill they had

was "on the job training" (p. 394) for complex care tasks, including lifting and transferring of sick elderly victims. Current research shows evidence that females continue as the primary care providers to the aged, as well as to chronically ill, elderly veterans.

Archbold (1983) studied 30 women caregivers of functionally impaired parents (p. 44); Barusch (1988) interviewed 89 spouse caregivers, 65% of whom were females. A Coping Inventory list identified caregivers' lack of care management skills, and physical difficulty in task performance. Transferring the elderly was especially problematic (p. 681). Furthermore, Brody's study (1981) of middle-aged women caregivers helped her determine that it is indeed female spouses, daughters, and daughters-in-law who are primary caregivers now, and likely to be so in the future (p. 474). In addition, a study by Crossman, London, and Barry (1981) add to the list of older females caring for disabled husbands. Their group of participants is identified as a high risk group due to the demands for, and inadequate preparation in, caregiving. Special problems were faced by these women as they cope with the added role of caregivers as well as their own aging process (p. 464). In addition, Fengler and Goodrich (1979) conducted multiple interviews of disabled husbands and found the wives also suffered from chronic ailments. Fengler and Goodrich

referred to these elderly wives as "hidden patients" (p. 177). The wives' low morale was partly related to the husbands' disabling condition; the wives reported at least one chronic physical problem and psychosocial concerns. The implication is that protecting the wives from health breakdown prevents their hospitalization, and thereby helps prevent institutionalization of the elderly, disabled husband.

Elderly, chronically ill veterans' spouses were interviewed by Gaynor (1989). She found that 87 spouses were initially happy in their duties, but by 32 months the caregivers became ill, and felt isolated (p. 121). Research conducted by Lovett and Gallagher (1988) found that 83% of respondents were female caregivers of impaired elderly spouses, parents, and parents-in-law (p. 323). Assessment of stress and depression were measured through self-report mechanisms.

The studies reflect the predominance of females as caregivers; themes are centered on dissatisfaction of caregivers because they lack caregiving skills, including lifting and transfers of the elderly impaired. Health breakdown, advancing age, and lack of skills are frequently mentioned as characteristics of female caregivers.

A different group of caregivers was identified by Cantor (1983): friends, neighbors, volunteers, and public

agencies (p. 599). The greater number of respondents in Cantor's study were male. Additional data about non-family members of the same age as the patient as available social support networks was reported by Chappell (1983). Much of the support is through friendly interactions.

The trend to include people outside the family as caregivers may continue, given the changing family unit, but this remains to be seen. Certainly the caregivers' relationship to the elderly, chronically ill veteran makes a difference in the consequences of care. According to Cantor (1983), strain occurs with greater severity in spouse caregivers and other close relatives, than in groups who are not related to the elderly, chronically ill person (p. 603).

Consequences of Caregiving

Three categories of consequences of caregiving will be discussed. The first category is personal, then family issues, and finally, societal influences.

Mace and Rabins (1981) describe personal experience of caregivers of persons suffering from Alzheimer's Disease. However, the relentless effects of other chronic illnesses such as Diabetes Mellitus, Chronic Obstructive Pulmonary Disease, Cardiovascular Accident (CVA), and Arthritis evoke similar feelings in caregivers of chronically ill, elderly veterans. There are indications that the closer the emotional bond, the closer the contact with the disabled

person (Cantor, 1983). The greater the disability, the more physical demands on the caregiver herself (Crossman & Kaljean, 1984), which in turn indicates the degree of dependence on the part of the elderly victim. Ebrahim & Nouri (1987) found that some wives gave up their jobs, and reported lack of social life as well as inability to cope with the elderly's disability (p. 172). Anger, guilt feelings, or fears are emotional feelings experienced by caregivers of chronically ill spouses (Farkas, 1980).

Further evidence is added by two international studies. Graycar and Kinnear (1983) found female spouses and daughters in the caregiver role of elderly persons in Australia. Their surveys show the effects on families of the elderly infirm. Caregivers report deteriorating health, mental distress, and depleting financial resources. Jones and Vetter (1984) interviewed 256 caregivers in Britain. Their findings reveal complaints of psychological distress among caregivers due to loss of social life, personal care to incontinent elderly, and little help from other people (p. 514). In addition, Maletta and Hepburn (1986) note the lack of caregiver training, and stress from feeling inadequate in her role, and feelings of isolation (p. 82).

Commonly mentioned as personal consequences of caregiving are stress due to lack of training in caregiving tasks, social isolation, and decreasing health of the

caregiver. Orem's universal self-care requisites include the need for periods of solitude (personal time), and social interactions (1980, p. 44). Complaints of feeling isolated and needing rest, and the need for promotion of human function and well-being are related to the female caregiver of chronically ill, elderly veterans, and to concepts in Orem's self-care model (1980).

Marital history is an important factor in the likelihood of a spouse as long-term caregiver, and lack of family or social supports are among the stressful factors noted by Berman, Delaney, Gallagher, Atkins, and Graeber (1987, p. 583). Additional stress comes from criticism and dissatisfaction expressed by family members regarding the caregiver's methods of care and living arrangements (Brody & Lang, 1982, p. 19). Cantor (1983) speaks to the quality of the relationship between care receiver and caregiver; she reports that spouses and children scored lower in ability to get along with care receivers, while friends and neighbors scored higher (p. 599).

Societal influences also impact on caregivers in other ways. Lack of follow-up care by health organizations, unavailability of community supports to elderly who live with family, and financial constraints are noted by respondents in Archbold's (1980) and Cantor's (1983) research. Arling and McAuley (1983) found that finances

were not a major strain to caregivers, or the reason for institutionalizing impaired elderly persons. Instead, Arling and McAuley (1983) uncovered a whole set of issues, ethical and social that would be involved when developing policy on public payment for family caregiving. On the other hand, extending homemakers' services to married couples is advocated by Fengler and Goodrich (1979) as part of their policy recommendations. In some cases caregivers are simply not made aware of community resources available to them. Nurses can take an active supportive-educative role and impart information to female caregivers. It needs to be said that older cohorts may be wary of community assistance and will not readily accept outside help. Nevertheless, caregiver intervention is required.

Caregiver Interventions

Various ways of lending support to caregivers are documented. Gallagher (1985) notes that many interventions are devised according to need, and refers to them as "pressed for service" (p. 254). Indeed, support groups have been helpful to the Alzheimer's group, and other groups such as Stroke clubs allow for ventilation of feelings, and provide social support, and an exchange of information on how to accomplish tasks (p. 269). As Maletta and Hepburn (1986) note, it is not always convenient, and transportation may not be available, to attend support groups. Therefore,

interventions must be planned for ahead of time. For hospitalized elderly veterans, task training must begin before they are discharged to the community, and the caregiver is consulted in the plan of care (Shine, 1983, p. 403).

Nurses are in the forefront to lead caregiver interventions through a supportive-educative role. The caregiver benefits from the physical support of the nurse as new skills are learned (Orem, 1980, p. 65), and stress from lack of knowledge is replaced by self-care ability.

Most older people consider themselves healthy individuals (Brody, 1981) despite chronic ailments. As long as they are self-sufficient enough to meet their daily needs, they function well. An inherent will and ability allow female caregivers to take on the care of their elderly family members; it is up to the nurse to protect the caregiver's health through a step-by-step approach in standing transfer techniques in order to conserve the caregiver for as long as possible. DeFriese and Woomert (1983, p. 3) identified 25 programs to encourage self-care among the elderly. Some are commercialized high-level wellness, and preventive medicine programs (p. 9). Others raise the question of how much of professional skills to give up to lay caregivers (p. 11). Many programs have been initiated by target groups; for example, support programs

for caregivers of disabled elderly, health education, and counseling for well-being. The small groups are led by a health professional and are held in public settings (p. 15). Neither goals, nor program evaluations are available.

Rehabilitation training is another intervention offered through practice sessions in psychomotor skills, and other teaching styles appropriate to the caregiver (Diehl, 1989, p. 262). Orem's supportive-educative role is applicable to Diehl's recommendations of combining a variety of teaching methods including an environment conducive to learning (Diehl, 1989, p. 263; Orem, 1980, p. 101). Education of female caregivers for specific disease information is a successfully reported intervention. The importance of learning management techniques and where to turn to for community resources is stressed by Lipkin, and Faude (1987, p. 24). Program evaluation exemplifies the advantage of the primary nurses in the supportive-educative role as they support and guide the families in their experience with Alzheimer's Disease (p. 26). A search of intervention studies of phenomena related to chronic health problems reveals the variety of human responses to chronic illness that must be considered when planning education as a nursing intervention (Pollock, 1987, p. 636).

Summary

Orem's (1980) self-care model provides for placing responsibility for management of self-care on the elderly, chronically ill veteran, and on the caregiver. Decreased length of hospitalization and caregiving resources makes self-care a requirement for home based care. The advantage to the caregiver are the veteran's increased skills and independence. This enables the caregiver to feel secure when leaving the veteran with a "sitter." She can plan time for herself, or to attend to personal errands. In addition, the caregiver learns skills such as standing transfer techniques through the nurse's supportive-educative role of guidance and teaching (Orem, 1980, p. 101).

The literature reflects the predominance of females as caregivers of elderly, chronically ill persons. Themes are centered on the consequences of caregiving and their impact on the caregivers. Advancing age, lack of caregiving skills, social isolation, and stress are frequently mentioned. Numerous caregiving interventions are reported in the studies; however, goals and outcome of interventions are not specified.

Chapter 3

METHODOLOGY

This chapter describes the methodology used for data collection in the study. It is organized into several sections. First the research design will be identified. Next, the instruments used for data collections will be described. Following this is a section that describes the sample and setting. Lastly, the specific procedures followed to collect these data will be described.

Research Design

The purpose of the study was to examine the caregiver-veteran dyad's performance of specific standing transfer techniques. The study used a descriptive, exploratory research design that utilized a convenience sample. Prospective data were collected by this researcher at a VAMC in northern California between November 1988 and April 1989. These data were analyzed using descriptive statistics such as frequencies and percentages.

Instruments

Survey

The investigator-prepared tool was a 20-item questionnaire that used a Likert-type Scale for the caregiver to mark responses accordingly. The structured questionnaire asked for information about skills involved in standing transfer techniques. The questionnaire was based

upon Ellwood's transfer methods (1982, p. 473), and skills training described by nurses who provided training at this specific Veterans Medical Center. The instrument was used to help identify skills training received by the caregiver dyads. In addition, a caregiver profile checklist asked questions about each caregiver's age range, perception of health status, and relationship to the veteran. Checklists developed by the investigator to evaluate step-by-step standing transfer techniques were used during the caregiver-veteran dyad demonstration. Seven steps described the standing transfer techniques on the checklists. The tools were not tested by caregiver-veteran dyads prior to implementation.

The questionnaire was reviewed by a panel of nurse specialists including the Nurse Coordinator of the Geriatric Evaluation Unit, a Gerontological Nurse Specialist, a Psychiatric Nurse Specialist, and a Gerontological Nurse Practitioner. Changes were made to clarify questions as needed. The checklists, also developed by the nurse investigator, based on personal training in standing transfer techniques, were reviewed by a Physical Therapist, a Gerontological Clinical Nurse Specialist, a Gerontological Nurse Practitioner, and a Nurse Ccordinator of Ambulatory Care Service. Changes in both tools were made according to their suggestions, thus consensus validation was achieved.

Sample

This study sample consisted of six female caregivers, and six chronically ill, elderly veterans, thus comprising six dyads. The dyads met the following criteria. Caregivers were female, aged 45 years and older; caregivers were also spouses, daughters, daughters-in-law, or friends of the elderly veteran and had participated in the VAMC-Geriatric Evaluation Unit's standing transfer training program. Veterans had the following characteristics: 65 years and over, alert and able to transfer with assistance, but without the use of a slide board. In addition, the veterans may have had one or more of the following chronic conditions: Diabetes Mellitus, Cardiovascular Accident, Chronic Obstructive Pulmonary Disease, or Peripheral Vascular Disease. However, none had a primary diagnosis of Carcinoma, Chemical Dependence, or Substance Abuse.

Setting

The setting for the study was a Department of Veterans Affairs Medical Center located in northern California. The setting has 164 operating beds of which 90 are designated as medical care beds, including intensive care beds; 60 are designated as extended care beds; 10 beds are assigned to rehabilitation medicine; and 4 beds are assigned to a specific intensive unit known as a Geriatric Evaluation Unit. The Geriatric Evaluation Unit admits elderly,

chronically ill veterans with rehabilitation potential. These are often elderly patients from World War II who are aged 65 years and older. Upon discharge the elderly veterans continue health maintenance through the Ambulatory Care Service, an outpatient unit. Comprehensive care that includes medical care, patient education, and rehabilitative care are all provided on an outpatient basis.

A multidisciplinary team serves elderly veterans on the Geriatric Evaluation inpatient unit and veterans in the Ambulatory Care Service. Staff simply rotate from service to service. A different group of licensed nurses serves veterans in the Geriatric Evaluation unit. These nurses are not the same ones serving elderly veterans in the Ambulatory Care Service. The nurses in Ambulatory Care do not rotate.

Procedure to Obtain the Population

Permission to conduct the study was granted by both the Institutional Review Board, Human Subjects of San Jose State University, and the Human Subjects Committee of the Department of Veterans Affairs Medical Center (see Appendix D and Appendix E).

The nurse investigator worked as clinician in the Ambulatory Care Service. She approached the Acting Head of Rehabilitation Medicine for access to a sample of caregiver-veteran dyads. A sample of 21 dyads was provided. However, after consulting with the discharge planning nurse and the

social worker, she learned that not all dyads met the sample criteria. From 21 potential dyad participants, the list was decreased by 4. The 17 remaining potential dyads were approached, and 12 met the sample criteria. The caregiver-veteran dyads were contacted in the Ambulatory Care Outpatient Service. It took 3 months to access these dyads because of the time span between clinical appointments.

Invitational letters, and informed consent forms were mailed to the 12 dyads (see Appendix F and Appendix G). Stamped self-addressed return envelopes were included, and a reminder was mailed by the investigator after 10 days to those who had not responded. Nine dyads responded, but only six data sets were usable.

Procedure for Data Collection

After consent forms were received by the investigator, the appointment for data collection was scheduled. For the participant's convenience, data were collected on the same day as the veteran's medical appointment. The time required for data collection from each respondent was 45 minutes. Twenty minutes for answering the questionnaire related to standing transfer training, and to respond to three questions on the caregiver profile. The veteran waited in the wheelchair while the caregiver completed the questions. Twenty-five minutes were devoted to the demonstration of standing transfer techniques. The caregiver-veteran dyad

demonstrated how the veteran transferred: From the wheelchair to bed, and back to wheelchair; from wheelchair to regular chair, and back to wheelchair; from wheelchair onto and off of the toilet, and back to wheelchair. As the dyad performed standing transfer techniques, the investigator observed, and checked the appropriate steps on the checklist. The investigator marked "yes" or "no" to indicate caregiver performance of each step.

Data Analysis

Descriptive statistics were used to analyze the data. Findings from the questionnaires, caregiver profile, and checklists are reported in frequencies and percentages. More specifically, findings from six questions on the questionnaire related to standing transfer techniques were analyzed. All findings from the demonstration checklists are reported in the form of frequencies and percentages.

Chapter 4

ANALYSIS AND INTERPRETATION OF DATA

The research question posed in this study was: Is the caregiver-veteran dyad performing standing transfer techniques according to training? If not, what are the consequences if the standing transfer techniques are not performed according to training?

In this chapter the results of data collected are discussed. The first topic for consideration is responses to the questionnaire on standing transfer techniques. Of the 20-item questionnaire, 6 items are specifically related to the three methods of standing transfer techniques taught to caregivers. These were: Methods of moving the veteran in and out of bed, standing transfer from wheelchair to chair; helping the veteran onto and off the toilet, moving the veteran from a sitting position to a standing position, placing the veteran on his unaffected side for transferring from wheelchair to toilet, and holding onto the veteran for transfer from wheelchair to toilet.

The first specific standing transfer technique addressed was transfer of the veteran from wheelchair to bed and back to wheelchair. The related questions that elicited responses were: (a) Skills training included methods of moving the veteran in and out of bed. (b) Directions for moving the veteran from a sitting position to a standing

position were demonstrated by the nurse. The second technique addressed was transfer of the veteran from wheelchair to chair and back. The related questions that elicited responses were: (a) Skills training included standing transfer from wheelchair to chair. (b) Directions for moving the veteran from a sitting position to a standing position were demonstrated by the nurse. The third technique addressed was transfer of the veteran from wheelchair to toilet and back. The related questions that elicited responses were: (a) Instructions were given on how to help the veteran onto and off the toilet. (b) Directions for moving the veteran from a sitting position to a standing position were demonstrated by the nurse. (c) Training on which side to place the veteran for transferring from wheelchair to toilet was covered by the nurse. (d) Instructions on how to hold onto the veteran for transferring from wheelchair to toilet was given by the nurse. A frequency distribution of these three separate standing transfer techniques was done.

Findings related to the standing transfer techniques taught to caregivers for moving the veteran in and out of bed were as follows: Two respondents said the training they received was adequate. They strongly agreed that it should be given to caregiver-veteran dyads. Two respondents found the training inadequate, and did not agree that it was

useful. The other two respondents reported mixed feelings about the training. They agreed that part of the training was adequate. The other part of the response was not adequate, therefore they disagreed with that part of the training.

Regarding standing transfer technique to help the veteran in and out of a chair, two respondents said the training was adequate; they strongly agreed that it should be offered to other caregivers. One respondent said the training was adequate. Two other respondents found the training inadequate. They contend that a one-time session with this particular skill is not sufficient. One respondent said part of the training was adequate, while part of it was not.

Data for standing transfer techniques to help the veteran on and off the toilet revealed that two respondents reported the training was inadequate. They did not agree with any part of it. Two respondents said the training was adequate. They strongly agreed that the training was useful. Two other respondents said part of the training was adequate, and part was not adequate. The main reasons given verbally by the respondents who disagreed with the training were "needed more than one lesson," and "should spend more time with the part I didn't know."

The caregivers were asked if they were included in planning for training needs. Fifty percent (3) agreed that they were included, and 50% (3) disagreed because they were not included. Three questions related to prevention of back injury were: (a) I am able to describe four steps to help prevent back injury to myself. (b) I received instructions on four steps to prevent back injury to myself. (c) The four steps on how to prevent back injury to myself were clear to me. The responses to question (a) were four (67%) of the caregivers disagreed to being able to describe four steps to help prevent back injury. One (17%) strongly agreed, and one (17%) agreed. The caregivers were consistent in their replies to (b), and (c) as well. Four (67%) disagreed to receiving instructions to prevent back injury. One (17%) strongly agreed, and one (17%) agreed. Similarly, four (67%) of the caregivers disagreed to being clear on the four steps to prevent back injury. One (17%) strongly agreed, and one (17%) agreed.

Given the physical and psychological strain of caring for an elderly veteran whose self-care abilities are limited in any way, it is essential that all the instructions and training sessions for the caregiver-veteran dyad include consideration of the potential effects on the caregiver. One area of concern for caregivers noted from the questionnaire was lack of information on how to prevent back

injury to the caregiver who assists the veteran in standing transfers.

Demonstration of caregivers' performance in three modalities of standing transfer techniques included seven steps. Each transfer performed was marked "yes" or "no" on the checklist indicating whether or not the caregiver took that step. In this narrative, the seven steps will be identified by letters of the alphabet (a-g). However, in the tables, the seven steps for transfer will be identified by number (1-7). The seven steps for transfer from wheelchair to bed included: (a) Caregiver will place wheelchair with veteran's strong side toward bed, 50% (3) of the respondents complied with the step, and 50% (3) respondents did not. (b) Caregiver makes sure the brakes on the wheelchair are locked. One hundred percent of respondents made sure the brakes on the wheelchair were locked, which indicated a strong safety factor. (c) Caregiver should tell veteran to move forward in chair. Fifty percent (3) of the caregivers told the veteran to move forward in the chair, and 50% (3) did not. (d) Caregiver tells veteran to use his strong hand to hold for support on armrest of wheelchair. Thirty-three percent (2) caregivers told the veteran to use his strong hand to hold onto the armrest of the wheelchair for support, and 67% (4) did not. (e) Caregiver tells veteran to stand (caregiver will steady

veteran if necessary by placing her hands on both sides of veteran's rib cage). Two (33%) told the veteran to stand, and four (67%) did not. (f) Caregiver tells veteran to pivot on his strong foot toward bed, two (33%) told the veteran to pivot on his strong foot, and four (67%) did not. (g) Caregiver should have the veteran sit on side of bed and swing his legs onto the bed. Two (33%) respondents told the veteran to sit on the side of the bed and swing his legs onto the bed, while four (67%) did not (see Table 1).

The reason the caregivers did not perform the steps was because the veterans did most of the standing transfer techniques as they were trained. Motivation and ability enabled the elderly veterans to engage in self-care activities.

When transferring veteran from bed to wheelchair, caregivers were evaluated on the following: (a) Caregiver places wheelchair at head of bed facing toward foot of bed. Four (67%) of the respondents placed the wheelchair at the head of the bed facing toward the foot and two (33%) did not. (b) Caregiver makes sure the brakes on the wheelchair are locked. One hundred percent (100%) of the respondents made sure the brakes on the wheelchair were locked, and indicated a strong safety factor. (c) Caregiver tells veteran to sit at edge of bed. Two (33%) of the respondents told the veteran to sit at the edge of the bed, and four

Table 1

Performance Scores of Caregivers in Standing Transfer Techniques per Steps on Checklist for Wheelchair to Bed (N=6)

	Caregiver Performance	
Steps	Yes	No
1	3 (50%)	3 (50%)
2	6 (100%)	0 (0%)
3	3 (50%)	3 (50%)
4	2 (33%)	4 (67%)
5	2 (33%)	4 (67%)
6	2 (33%)	4 (67%)
7	2 (33%)	4 (67%)

Note. Percentages are rounded to nearest whole percent.

(67%) did not. (d) Caregiver tells veteran to use his strong hand to support himself on the bed. Two (33%) of the respondents told the veteran to use their strong hands to support themselves on the bed, and four (67%) did not. (e) Caregiver tells veteran to stand (caregiver will steady veteran if necessary by placing her hands on both sides of veteran's rib cage). Again, two (33%) of respondents complied while four (67%) did not. (f) Caregiver tells veteran to pivot on his strong foot toward the wheelchair. Two (33%) respondents told the veteran to pivot on his strong foot toward the wheelchair, and four (67%) did not. (g) Caregiver tells veterans to sit in the wheelchair. Two respondents (33%) performed the step, but four (67%) did not (see Table 2).

The respondents assisted as necessary, otherwise they allowed the veteran to do the standing transfer by himself. Physical exertion was minimized for the caregiver when the elderly veteran practiced self-care.

The seven steps for transferring the veteran from wheelchair to chair included: (a) Caregiver should place wheelchair close to the regular chair, but 50% (3) did not. (b) Caregiver makes sure the brakes on the wheelchairs are locked. Six (100%) of the respondents made sure the brakes on wheelchairs were locked. (c) Caregiver tells veteran to move forward in wheelchair. Three (50%) of the respondents

Table 2

Performance Scores of Caregivers in Standing Transfer Techniques per Steps on Checklist for Bed to Wheelchair (N=6)

Steps	Caregiver Performance	
	Yes	No
1	4 (67%)	2 (33%)
2	6 (100%)	0 (0%)
3	2 (33%)	4 (67%)
4	2 (33%)	4 (67%)
5	2 (33%)	4 (67%)
6	2 (33%)	4 (67%)
7	2 (33%)	4 (67%)

Note. Percentages are rounded to nearest whole percent.

told veterans to move forward in the wheelchair, and three (50%) did not. (d) Caregiver tells veteran to use his strong hand to hold onto armrest of wheelchair for support. Once again, three (50%) of the caregivers told the veteran to use his strong hand to hold onto the armrest of the wheelchair for support, and three (50%) did not comply with the step. (e) Caregiver tells veteran to stand (caregiver will steady veteran if necessary by placing her hand on both sides of veteran's rib cage). Four (67%) caregivers did not tell the veteran to stand and two (33%) did. (f) Caregiver tells the veteran to pivot on his strong foot toward the chair. Again, four (67%) did not tell the veteran to pivot on his strong side, and two (33%) did. (g) Caregiver tells veteran to sit in the chair. Five (83%) caregivers did not tell the veteran to sit in the chair, and one (17%) did (see Table 3).

When transferring the veteran from chair to wheelchair, the caregiver was evaluated on these seven steps: (a) Caregiver places wheelchair on veteran's strong side. Fifty percent (3) of the respondents placed the wheelchair on the veteran's strong side, and 50% (3) did not. (b) Caregiver makes sure the brakes on the wheelchair are locked. Six (100%) respondents made sure the brakes on the wheelchair were locked. (c) Caregiver tells veteran to move forward in chair. Two (33%) respondents told the veterans to move

Table 3

Performance Scores of Caregivers in Standing Transfer Techniques per Steps on Checklist for Wheelchair to Chair (N=6)

	Caregiver Performance	
Steps	Yes	No
1	3 (50%)	3 (50%)
2	6 (100%)	0 (0%)
3	3 (50%)	3 (50%)
4	3 (50%)	3 (50%)
5	2 (33%)	4 (67%)
6	2 (33%)	4 (67%)
7	1 (17%)	5 (83%)

Note. Percentages are rounded to nearest whole percent.

forward in the chair, and four (67%) did not. (d) Caregiver should tell the veteran to use his strong hand to hold onto the armrest of wheelchair for support. Four (67%) of the caregivers did not tell the veteran to hold onto the armrest of the wheelchair for support, and two (33%) did. (e) Caregiver tells veteran to stand (caregiver will steady veteran if necessary by placing her hands on veteran's rib cage). One (17%) respondent told the veteran to stand, and five (83%) did not. (f) Caregiver should tell veteran to pivot on his strong foot toward the wheelchair. Five (83%) of the caregivers did not tell the veteran to pivot on his strong foot while one (17%) caregiver did. (g) Caregiver tells veteran to sit in wheelchair. All six (100%) caregivers did not tell the veteran to sit in the wheelchair (see Table 4).

When transferring the veteran from wheelchair to toilet, caregivers were checked on their performance of the following. (a) Caregiver makes sure the brakes on the wheelchair are locked. Six (100%) of the respondents did indeed check to see that the brakes were on. (b) Caregiver reminds veteran to loosen clothing from belt area. Fifty percent (3) reminded the veteran to loosen his clothing from his belt area, and 50% (3) did not. (c) Caregiver tells veteran to move forward in chair. Two (33%) of the caregivers told the veteran to move forward in the chair,

Table 4

Performance Scores of Caregivers in Standing Transfer Techniques per Steps on Checklist for Chair to Wheelchair (N=6)

	Caregiver Performance	
Steps	Yes	No
1	3 (50%)	3 (50%)
2	6 (100%)	0 (0%)
3	2 (33%)	4 (67%)
4	2 (33%)	4 (67%)
5	1 (17%)	5 (83%)
6	1 (17%)	5 (83%)
7	0 (0%)	6 (100%)

Note. Percentages are rounded to nearest whole percent.

but four (67%) did not. (d) Caregiver tells veteran to use his strong hand to hold onto the armrest of the wheelchair for support. Four (67%) of the caregivers did not tell the veteran to use his strong hand to hold onto the armrest of the wheelchair for support, and two (33%) did. (e) Caregiver tells veteran to stand (caregiver will steady veteran if necessary by placing her hands on both sides of the veteran's rib cage). Three (50%) of the caregivers told the veteran to stand, and a caregiver held onto the veteran's neck instead of the sides of his rib cage. She said "that was easier for me." Three (50%) did not follow directions. (f) Caregiver tells veteran to pivot on his strong foot toward toilet. Two (33%) of the caregivers told the veteran to pivot on his strong foot, and four (67%) did not. (g) Caregiver tells veteran to sit on toilet. One (17%) caregiver told the veteran to sit on the toilet, and five (83%) did not (see Table 5).

When transferring the veteran from toilet back to the wheelchair, the caregiver was checked on performance of the following: (a) Caregiver makes sure brakes on wheelchair are locked. Six (100%) of the caregivers made sure that the brakes on the wheelchair were locked. (b) Caregiver reminds veteran to pull up his clothing. Fifty percent (3) of the caregivers reminded the veteran to pull up his clothing, and 50% (3) did not. (c) Caregiver tells veteran to move

Table 5

Performance Scores of Caregivers in Standing Transfer Techniques per Steps on Checklist for Wheelchair to Toilet (N=6)

Steps	Caregiver Performance	
	Yes	No
1	6 (100%)	0 (0%)
2	3 (50%)	3 (50%)
3	2 (33%)	4 (67%)
4	2 (33%)	4 (67%)
5	3 (50%)	3 (50%)
6	2 (33%)	4 (67%)
7	1 (17%)	5 (83%)

Note. Percentages are rounded to nearest whole percent.

forward in wheelchair. Two (33%) caregivers told the veteran to move forward in the chair, while four (67%) did not. (d) Caregiver tells veteran to use his strong hand to hold onto the armrest of the wheelchair for support. Two (33%) of the caregivers told the veteran to use his strong hand to hold onto the armrest of the wheelchair for support, and four (67%) did not. (e) Caregiver tells veteran to stand (caregiver will steady veteran by placing her hand on both sides of veteran's rib cage). Two (33%) of the caregivers told the veteran to stand on his strong foot, and four (67%) did not. (f) Caregiver tells veteran to pivot on his strong foot toward wheelchair. Two (33%) of the cargivers told the veteran to pivot on his strong foot, and four (67%) did not. (g) Caregiver tells veteran to sit in the wheelchair. Thirty-three percent (2) of the caregivers told the veteran to sit in the wheelchair, and four (67%) did not (see Table 6).

Overall, the caregiver did not physically exert herself because the veteran was able to engage in self-care. One caregiver hovered over the veteran unnecessarily. She tried to help the veteran even though he did not need help. On the other hand, one caregiver performed several steps in standing transfer techniques together with the veteran since he seemed weaker than the other veterans. This caregiver considered her health in excellent condition. In fact, most

Table 6

Performance Scores of Caregivers in Standing Transfer Techniques per Steps on Checklist for Toilet to Wheelchair (N=6)

	Caregiver Performance	
Steps	Yes	No
1	6 (100%)	0 (0%)
2	3 (50%)	3 (50%)
3	2 (33%)	4 (67%)
4	2 (33%)	4 (67%)
5	2 (33%)	4 (67%)
6	2 (33%)	4 (67%)
7	2 (33%)	4 (67%)

Note. Percentages are rounded to nearest whole percent.

of the respondents considered themselves in excellent to fair health.

The caregiver profile was a self report of the caregiver's age range, perceived health status, and the relationship to the elderly veteran. One caregiver reported being in the 45 to 55 age range, she said she was in excellent health, and reported her relationship as girlfriend. Four caregivers reported their ages in the 56 to 65 age range, one was in the 66 to 75 range, and no one was in the 76 and over age range. One caregiver in the 56 to 65 age range reported being in good health, and was a spouse. Two caregivers in the 56 to 65 age range reported being in fair health; they said they were spouses of the elderly veterans. One caregiver in the 66 to 75 age range reported being a spouse in fair health. None reported being in poor health. The caregiver literature includes findings related to the caregiver's health. For instance, Gaynor (1989) found that spouses were considered healthy, but became ill after a 32-month period of caregiving. None of the caregivers in this study were daughters, nor daughters-in-law (see Table 7).

Table 7

Caregiver Profile Self-Report Results by Frequency and Percentage (N=6)

Categories	Number of Responses	Percentage of Respondents
	Age Range	
45 to 55	1	17
56 to 65	4	67
66 to 75	1	17
76+	0	0
	Health	
Excellent	2	33
Good	1	17
Fair	3	50
Poor	0	0
	Relationship	
Spouse	5	83
Daughter	0	0
Daughter-in-Law	0	0
Friend	1	17

Note: Percentages are rounded to nearest whole percent.

Chapter 5

CONCLUSIONS AND RECOMMENDATIONS

Conclusions

This was an exploratory study to discover whether or not caregiver-veteran dyads were performing standing transfer techniques as trained by nurses in the Geriatric Evaluation Unit. The data collected revealed that only two of the six caregiver-veteran dyads in the study performed all steps in the standing transfer techniques. However, the data collected also indicated that some of the steps seemed unnecessary because of the veteran's ability to move himself from one place to another; when this was the case, the caregiver simply stood by and prompted the veteran if he seemed to forget a step.

The data and information collected in the study also suggested that caregiver-veteran dyads do not consider a single training session sufficient. Further, the findings suggested that caregivers should be included more consistently in planning instruction on standing transfer techniques, so that individualized needs of each dyad can be met. Even the two caregiver-veteran dyads who performed all the steps and stated that they agreed with all aspects of training in standing transfer techniques expressed their

excluded from the literature. Shine (1983) recommends consulting the caregiver in the plan of care well before the hospitalized elderly veteran is discharged to the community.

The study did not reveal any data indicating that training caregiver-veteran dyads in standing transfer techniques is unnecessary or without value. On the contrary, even the caregivers who did not think all the steps were necessary agreed that one training lesson was not enough to become proficient in performing the transfers. In fact, a single lesson might be potentially harmful to the caregiver-veteran dyad, for it could result in a false sense of confidence that both people know how to perform the transfer; this in turn could lead to a fall or other injury. Or, if caregivers do not feel proficient in the techniques for standing transfers, they may be reluctant to move the veteran very often, even when doing so would make him more comfortable. Some caregivers also resort to use of the slide board when they do not feel sure of their skills in assisting with standing transfers. This prevents the veteran from participating in self-care.

Certainly, the caregiver-veteran dyad requires training in prescribed exercises that will help develop and maintain functional abilities of the affected veteran (Blechman, 1984; Maletta & Hepburn, 1986; Stoker, 1983). It is essential, however, to remember the nurse's supportive-

educative role in applying Orem's model when planning for this type of training. The goal of the training is to instruct the caregiver-veteran dyad in methods to manage health-deviation self-care. Standing transfers, the activity emphasized in this study, are among rehabilitative measures that help compensate for disabilities.

The study suggests that self-care abilities of both the elderly veteran and the caregiver are important factors that must be considered in designing training sessions for individual caregiver-veteran dyads. As the literature indicates, the greater the veteran's disability, the greater his physical dependence on the caregiver (Crossman & Kaljean, 1984). But the reverse is also true. Veterans with less severe disabilities should be less physically dependent on the caregiver. In her supportive-educative role, the nurse can provide opportunities for the caregiver to observe her as she assists the elderly veteran in self-care activities, such as standing transfer. The nurse and caregiver can plan training sessions that help the caregiver-veteran dyad continue to perform standing transfers in a safe manner when the veteran leaves the environment of the hospital.

Since caregivers are the main source of care and support of elderly, chronically ill veterans in the community, their health and well-being, as well as the

veteran's, must be protected. The nurse is still the one in the forefront to ensure that female caregivers' skills are updated prior to taking the elderly veteran home. Self-care approaches are ways to encourage the caregiver-veteran dyad to learn caregiving tasks to make home-based care easier for them.

Recommendations

The findings in this study suggest the following: More than one training session may be required before the caregiver considers herself proficiently skilled. Training sessions should be planned to meet the needs of individual caregiver-veteran dyads. Instruction and training for veteran-caregiver dyads should promote self-care activities as a way of decreasing physical dependence on the caregiver, and instruction and training should include information on preserving the caregiver's physical well-being. Principles of adult learning need to be incorporated in planning training sessions.

There were several limitations in the study. The sample was limited to a few cases, and only female caregivers were selected from a specific area. A larger sample of diverse types of caregivers would allow for comparisons, including those who had two or more training sessions. The tools could also be tested with a different group of caregivers. Since the tools were not tested by

caregiver-veteran dyads prior to implementation in the study, their reliability and validity are not assured. Given the limitations of the study, the findings can not be generalized to other caregivers. The investigator recommends the following for future studies: A larger sample, a variety of agencies, and multiple geographic sites.

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APPENDIX A

Caregiver Profile

Appendix A

Caregiver Profile

The following questions will give me general information about the caregiver. Please place check mark in the space that applies to you.

My age range is:	45-55	____
	56-65	____
	66-75	____
	76+	____
My health is:	Excellent	____
	Good	____
	Fair	____
	Poor	____
My relationship to veteran:	Spouse	____
	Daughter	____
	Daughter-in-law	____
	Sister	____
	Friend	____

APPENDIX B

Questionnaire

Appendix B

Caregiver Questionnaire

Directions: Place a circle around the letter of your choice. Select only one.

1. As a caregiver, I was included in planning the training needs:
   a. Strongly agree
   b. Agree
   c. Disagree
   d. Strongly disagree
2. Training was directed toward each caregiver's individuals needs:
   a. Strongly agree
   b. Agree
   c. Disagree
   d. Strongly disagree
3. I knew how to do standing transfers before the training sessions began:
   a. Strongly agree
   b. Agree
   c. Disagree
   d. Strongly disagree

4. Skills training included methods of moving the veteran in and out of bed.
   a. Strongly agree
   b. Agree
   c. Disagree
   d. Strongly disagree
5. Skills training included standing transfer from wheelchair to chair:
   a. Strongly agree
   b. Agree
   c. Disagree
   d. Strongly disagree
6. Instructions were given on how to help the veteran onto and off the toilet:
   a. Strongly agree
   b. Agree
   c. Disagree
   d. Strongly disagree
7. Directions for moving the veteran from a sitting position to a standing position were demonstrated by the nurse:
   a. Strongly agree
   b. Agree
   c. Disagree
   d. Strongly disagree

8. Hospital training of standing transfer is easy to use at home:
   a. Strongly agree
   b. Agree
   c. Disagree
   d. Strongly disagree
9. Training on which side to place the veteran for transferring from wheelchair to toilet was covered by a licensed nurse:
   a. Strongly agree
   b. Agree
   c. Disagree
   d. Strongly disagree
10. Instructions on how to hold onto the veteran for transferring from wheelchair to toilet was given by the nurse:
   a. Strongly agree
   b. Agree
   c. Disagree
   d. Strongly disagree

11. I was given more than one training session to learn standing transfers:
    a. Strongly agree
    b. Agree
    c. Disagree
    d. Strongly disagree
12. I was given only one training session to learn standing transfers:
    a. Strongly agree
    b. Agree
    c. Disagree
    d. Strongly disagree
13. I think training sessions should be held in the caregiver's home:
    a. Strongly agree
    b. Agree
    c. Disagree
    d. Strongly disagree
14. Training sessions allowed enough time for me to practice transfer techniques in the hospital:
    a. Strongly agree
    b. Agree
    c. Disagree
    d. Strongly disagree

15. I am able to describe four steps to help prevent back injury to myself:
    a. Strongly agree
    b. Agree
    c. Disagree
    d. Strongly disagree
16. I received instruction on four steps to prevent back injury to myself:
    a. Strongly agree
    b. Agree
    c. Disagree
    d. Strongly disagree
17. The four steps on how to prevent back injury were clear to me:
    a. Strongly agree
    b. Agree
    c. Disagree
    d. Strongly disagree
18. I think it is easier for me to help the veteran at home because of the training on transfer techniques:
    a. Strongly agree
    b. Agree
    c. Disagree
    d. Strongly disagree

19. The training sessions on transfer technique met my needs:
    a. Strongly agree
    b. Agree
    c. Disagree
    d. Strongly disagree
20. I would recommend training on transfer techniques to other female caregivers:
    a. Strongly agree
    b. Agree
    c. Disagree
    d. Strongly disagree

APPENDIX C

Demonstrate Standing Transfer

Appendix C

Checklist to Demonstrate Standing Transfer Techniques To and From Three Areas

The caregiver will demonstrate seven steps the veteran must follow during standing transfers:

Transfer #1 and back

A. To transfer veteran from wheelchair to bed:

1. The caregiver will place wheelchair with veteran's strong side toward bed.
2. The caregiver should make sure that the brakes on the wheelchair are locked.
3. The caregiver should tell the veteran to move forward in the chair.
4. The caregiver should tell the veteran to use his strong hand to hold onto the armrest of wheelchair for support.
5. The caregiver should tell the veteran to stand (caregiver will steady veteran if necessary by placing her hands on both sides of veterans rib cage).
6. The caregiver should tell the veteran to pivot on his strong foot toward the bed.
7. The caregiver should have the veteran sit on the side of the bed and swing his leg(s) onto the bed.

B. To transfer veteran from bed to wheelchair:

1. The caregiver will place wheelchair at head of bed facing toward foot of bed.
2. The caregiver should make sure that the brakes on the wheelchair are locked.
3. The caregiver should tell the veteran to sit at edge of bed.
4. The caregiver should tell the veteran to use his strong hand support himself on the bed.
5. The caregiver should tell the veteran to stand (caregiver will steady veteran if necessary by placing her hands on both sides of veterans rib cage).
6. The caregiver should tell the veteran to pivot on his strong foot toward the bed.
7. The caregiver should have the veteran sit in the wheelchair.

<u>Transfer #2 and back</u>

C. To transfer veteran from wheelchair to chair:

1. The caregiver should place wheelchair close to the chair.
2. The caregiver should make sure that the brakes on the wheelchair are locked.
3. The caregiver should tell the veteran to move forward in the chair.

4. The caregiver should tell the veteran to use his strong hand to hold onto the armrest of wheelchair for support.
5. The caregiver should tell the veteran to stand (caregiver will steady veteran if necessary by placing her hands on both sides of veterans rib cage).
6. The caregiver should tell the veteran to pivot on his strong foot toward the chair.
7. The caregiver should have the veteran sit on the chair.

D. To transfer veteran from chair to wheelchair:

1. The caregiver will place wheelchair on the veteran's strong side.
2. The caregiver should make sure that the brakes on the wheelchair are locked.
3. The caregiver should tell the veteran to move forward in the chair.
4. The caregiver should tell the veteran to use his strong hand to hold onto the armrest of wheelchair for support.
5. The caregiver should tell the veteran to stand (caregiver will steady veteran if necessary by placing her hands on both sides of veterans rib cage).

6. The caregiver should tell the veteran to pivot on his strong foot toward the wheelchair.
7. The caregiver should have the veteran sit in the wheelchair.

Transfer #3 and back

E. To transfer veteran from wheelchair to toilet:
   1. The caregiver should make sure that the brakes on the wheelchair are locked.
   2. The caregiver should tell the veteran to loosen clothing from belt area.
   3. The caregiver should tell the veteran to move forward his the chair.
   4. The caregiver should tell the veteran to use his strong hand to hold onto the armrest of wheelchair for support.
   5. The caregiver should tell the veteran to stand (caregiver will steady veteran if necessary by placing her hands on both sides of veterans rib cage) and finish pulling his pants down.
   6. The caregiver should tell the veteran to pivot on his strong foot toward the toilet.
   7. The caregiver should have the veteran sit on the toilet.

F. To transfer veteran from toilet to wheelchair:

1. The caregiver should make sure that the brakes on the wheelchair are locked.
2. The caregiver should remind the veteran to pull up his clothing.
3. The caregiver should tell the veteran to move forward on the toilet.
4. The caregiver should tell the veteran to use his strong hand to hold onto the armrest of wheelchair for support (if no rail available).
5. The caregiver should tell the veteran to stand (caregiver will steady veteran if necessary by placing her hands on both sides of veterans rib cage). The caregiver will pull up the veteran's pants.
6. The caregiver should tell the veteran to pivot on his strong foot toward the wheelchair.
7. The caregiver should have the veteran sit in the wheelchair.

APPENDIX D

San Jose State University Approval

SAN JOSE STATE UNIVERSITY
GRADUATE STUDIES AND RESEARCH

HUMAN SUBJECTS INSTITUTIONAL REVIEW BOARD
PROJECT PROPOSAL REVIEW

I, the undersigned member of the San Jose State University Human Subjects Institutional Review Board, have reviewed the following proposal submitted to the Committee on January 3, 1989 by:

PRINCIPAL INVESTIGATOR: Rose H. Martinez
PROTOCOL #: 7430 DEPT.: Nursing
PROJECT TITLE: A STUDY OF CAREGIVERS OF ELDERLY VETERANS

I recommend the following action (indicate one):

1. Approved for clearance as involving minimal risk to Human Subjects. ☑
2. Approved for clearance with risk to Human Subjects. ☐
3. Approved for clearance when the following conditions are met: ☐

4. Not Approved (return to principal investigator for following reasons): ☐

5. Expedited Review (specify condition[s] that merit expedited review): ☐

Robert J Lotin, M.D. 1/5/89
Signature of IRB-HS member **Date**

OFFICIAL SIGNING FOR INSTITUTION

1/19/89
Chair, Human Subjects Institutional Review Board **Date**

Serena Stanford 1/20/89
Serena Stanford, Ph.D. **Date**
AAVP for Graduate Studies & Research

San Jose State University Foundation
One Washington Square
San Jose, CA 95192-0139 (408) 924-1435

APPENDIX E

Agency Consents

INFORMATION ABOUT

A study of caregivers of elderly Veterans

1. A research study will be conducted at the Geriatric Evaluation Unit (GEU) of the Livermore VA Medical Center. The purpose of this study is to investigate the viewpoint of female caregivers of elderly, chronically ill veterans. The results of the study may help to enhance training techniques needed by caregivers. You are invited to participate in this study.

2. If I do agree to participate in this study, I can expect the following things to happen:

a. I will be interviewed individually.

b. I will be asked to answer an oral questionnaire. I will be asked to demonstrate three standing transfer techniques which will include transferring the veteran to and from a bed in the Geriatric Evaluation Unit; transferring the veteran from wheelchair to toilet, and back. Transferring the veteran from wheelchair to chair and back.

c. The estimated time for the demonstration is 25 minutes and 20 minutes for the questionnaire for a total participation time of 45 minutes.

3. I understand there are no identifiable risks to me associated with participation in this study.

4. I understand there are no direct benefits to be gained by participating in this study. all benefits are for future caregivers.

5. I understand that I may withdraw from this study at any time, whether or not I complete the questionnaire and demonstration. Also, I understand that if I do withdraw from the study, this decision will have no bearing on my present or future treatment at the Livermore VA Medical Center.

6. I understand that any information about me which comes from this research project will be confidential and I will not be identified in any personal way in papers or talks that result from this study. I understand this

confidentiality includes any questionnaires or demonstrations I complete.

7. The information on this page was explained to me by Rose H. Martinez, R.N., responsible investigator of this study. I understand that the investigator will answer any questions I may have about this study at any time. I can reach Mrs. Martinez at the Livermore VA Medical Center by calling (415) 447-2560, Extension 6244.

8. In the unlikely event you are injured as a result of participating in this study, the Livermore VAMC will furnish medical care as provided by Federal Statute. Compensation for such injury may also be available to you under the provisions of Title 38, United States Code, Section 310 or 151, or in some instances, under the provisions of the Federal Tort Claims Act [28 U.S.C. 1346 (5) and 2675]. For further information contact the VA District Legal Counsel at (415) 556-4656.

(Subject)

I, _____,
certify that the above written summary was discussed and explained to me by
_____
on this date.

_____ _____
(Date) (Signature)

or

(Subject's Legal Representative)

I, _____, the
_____ of
(relationship)
_____
(or legal status)
_____
(subject's name)
certify that the above written summary was discussed and fully explained to me by _____
on this date.

_____ _____
(Date) (Signature)

(Witness)

I, _____,
certify that I was present during the oral presentation of the above written

summary when it was given to the above subject/legal representative of the subject (circle one).

(Date) (Signature)

(Investigator) I have discussed the above points with the subject or his legally authorized representative. It is my opinion that the subject understands the risks, benefits and obligations involved in participation in this study.

(Date) (Signature)

Veterans Administration

December 12, 1988 84

In Reply Refer To: 111C

Dr. Bobbye Gorenberg, Graduate Coordinator
Department of Nursing
Graduate Program
San Jose State University
125 South 7th Street
San Jose, CA 95192

Dear Dr. Gorenberg:

Rose Martinez, R.N., a student in the Graduate Program, has my permission to do a research study for her master's thesis in the Ambulatory Care Service and Geriatric Extended Unit, VA Medical Center, Livermore, California

Sincerely,

Margaret A. Brick

MARGARET A. BRICK, R.N., C.N.A.A.
Chief, Nursing Service

cc: Rose Martinez, R.N., CCRN

APPENDIX F

Invitational Letter

Appendix F

Invitational Letter to Participants

Date

Dear _____:

I, Rose Martinez, am a registered nurse and a graduate student at San Jose State University. I am conducting a study of female caregivers of elderly veterans and would like you to consider participating in my study. The purpose of the study is to obtain your opinion about the training you received in transferring techniques from licensed nurses, and observe performance of standing transfer techniques.

The study is needed to help determine whether female caregivers think they are receiving adequate training in transfer skills from nurses before the veteran is discharged from the hospital.

It is hoped that this study will help improve training of female caregivers in transfer techniques in the future. If you and the veteran decide to participate, please sign the enclosed consent forms and mail them in the postage-paid return envelope. We will need 45 minutes for a return demonstration of three transfer techniques and for the caregiver to respond to a questionnaire. We can do this at the elderly veteran's next outpatient appointment in the Geriatric Evaluation Unit.

Thank you for your time.

Sincerely,

Rose Martinez

APPENDIX G

Consent Form

Appendix G

AGREEMENT TO PARTICIPATE IN RESEARCH AT

SAN JOSE STATE UNIVERSITY

RESPONSIBLE INVESTIGATOR: Rose H. Martinez, R.N., B.S.N.

TITLE OF PROTOCOL: A Study of Caregivers of Elderly Veterans

I have been asked to participate in a research study to investigate the viewpoint of female caregivers of elderly chronically ill veterans. The results of the study may help to enhance training techniques needed by caregivers.

I understand that:

(1) I will be asked to participate in a study conducted by Rose H. Martinez. I, the caregiver, will be asked to answer an oral questionnaire that will take approximately 20 minutes to complete. I will be asked to demonstrate three standing transfer techniques which will include transferring the veteran to and from a bed in the Geriatric Evaluation Unit; transferring the veteran from wheelchair to chair, and back; transferring the veteran from wheelchair to toilet, and back. The estimated time of the demonstration is 25 minutes. Total time of participation is 45 minutes.

(2) There are no possible risks in participating in this study.

(3) There are no real benefits for me participating in this study. All benefits are for future caregivers.

(4) There are no alternative procedures for the research study.

(5) The results from this study may be published, however, all results will be published in aggregate form. Therefore, any information about me will remain confidential and will be disclosed only with my permission or as required by law.

(6) The participants will not receive compensation for participating in this research project.

(7) If I have any questions, I can call Rose H. Martinez at (415) 447-2560, extension 6233, or Dr. Irene Lewis, her thesis advisor, at (408) 924-3160. For questions or complaints about research-related injury, I can contact Serena Stanford, Ph.D. (Associate Academic Vice President for Graduate Studies, San Jose State University) at (408) 924-2480.

(8) My consent is given voluntarily without being coerced. I may refuse to participate in this study or in any part of this study, and I may withdraw at any time, without prejudice to my relations with San Jose State University.

(9) I have been offered a copy of this consent for my file.

MY SIGNATURE INDICATES THAT I HAVE READ THE INFORMATION PROVIDED ABOVE AND THAT I HAVE DECIDED TO PARTICIPATE.

_____ _____

Date Subject's Signature

_____

Investigator's Signature